

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://ndpers.nd.gov/image/cache/shp-coi-gf.pdf> or by calling 1-800-499-3416 (toll free) | TTY/TDD: 1-877-652-1844 (toll-free). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call NDPERS Customer Service at 1-800-499-3416 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| What is the overall deductible? | Basic Providers: \$500 individual / \$1,500 family. PPO Providers: \$500 individual / \$1,500 family. | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> in your Summary Plan Document (SPD). |
| Are there other deductibles for specific services? | Yes. \$500 for infertility services. There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | Basic Providers: \$2,000 individual / \$4,500 family. PPO Providers: \$1,500 individual / \$3,500 family. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , balance-billing charges, <u>copay</u> amounts, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a network provider? | Yes. See www.sanfordhealthplan.com or call 1-800-752-5863 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider</u> network. You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the in-network <u>specialist</u> you choose without a <u>referral</u> . |

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|---|--|
| | | Basic Plan | PPO Plan | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$35 <u>copay</u> / visit | \$30 <u>copay</u> / visit | <u>Deductible</u> is waived. |
| | <u>Specialist</u> visit | \$35 <u>copay</u> / visit | \$30 <u>copay</u> / visit | |
| | <u>Preventive care/screening/Immunization</u> | \$35 <u>copay</u> / visit | \$30 <u>copay</u> / visit | <u>Deductible</u> is waived. 25% <u>coinsurance</u> for prostate cancer screening out-of-network and 20% <u>coinsurance</u> for in-network. See SPD for more information. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 25% <u>coinsurance</u> after <u>deductible</u> | 20% <u>coinsurance</u> after <u>deductible</u> | None |
| | Imaging (CT/PET scans, MRIs) | 25% <u>coinsurance</u> after <u>deductible</u> | 20% <u>coinsurance</u> after <u>deductible</u> | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sanfordhealthplan.com/pharmacy | Generic Formulary Drugs 0-34 days | \$7.50 <u>copay</u> / prescription | \$7.50 <u>copay</u> / prescription | Covers up to a 34-day supply. Two <u>copays</u> for a 35-100 day supply. \$1,200 <u>coinsurance</u> maximum per person per benefit period. Refer to your Formulary to determine which benefit applies to your medication. |
| | 35-100 days | \$15 <u>copay</u> /prescription Then 12% <u>coinsurance</u> | \$15 <u>copay</u> /prescription Then 12% <u>coinsurance</u> | |
| | Brand Name Formulary Drugs 0-34 days | \$25 <u>copay</u> / prescription | \$25 <u>copay</u> / prescription | |
| | 35-100 days | \$50 <u>copay</u> / prescription Then 25% <u>coinsurance</u> | \$50 <u>copay</u> / prescription Then 25% <u>coinsurance</u> | |
| | Non-Formulary Drugs 0-34 days | \$30 <u>copay</u> / prescription | \$30 <u>copay</u> / prescription | |
| | 35-100 days | \$60 <u>copay</u> / prescription Then 50% <u>coinsurance</u> | \$60 <u>copay</u> / prescription Then 50% <u>coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|---|--|
| | | Basic Plan | PPO Plan | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 25% <u>coinsurance</u> after deductible | 20% <u>coinsurance</u> after deductible | These services may require preauthorization / prior approval by the Health Plan. Please call NDPERS customer service at: 1-800-499-3416 for approval. |
| | Physician/surgeon fees | 25% <u>coinsurance</u> after deductible | 20% <u>coinsurance</u> after deductible | |
| If you need immediate medical attention | <u>Emergency room care</u> | \$60 <u>copay</u> / visit, then subject to deductible and then 20% <u>coinsurance</u> | \$60 <u>copay</u> / visit, then subject to deductible and then 20% <u>coinsurance</u> | Emergency room <u>copay</u> waived if directly admitted. Additional services done during an <u>Urgent care</u> visit may be subject to deductible / <u>coinsurance</u> . |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> after deductible | 20% <u>coinsurance</u> after deductible | |
| | <u>Urgent care</u> | \$30 <u>copay</u> / visit | \$30 <u>copay</u> / visit | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 25% <u>coinsurance</u> after deductible | 20% <u>coinsurance</u> after deductible | Prior authorization required. Please call NDPERS Customer Service at: 1-800-499-3416 for approval. |
| | Physician/surgeon fees | 25% <u>coinsurance</u> after deductible | 20% <u>coinsurance</u> after deductible | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services Office visit: \$35 <u>copay</u> / visit Other outpatient services: 20% <u>coinsurance</u> after deductible | | \$30 <u>copay</u> / visit 20% <u>coinsurance</u> after deductible | For outpatient services, the first 5 visits of any calendar year will be covered at 100% (no charge). For full details, please refer to your policy. Prior authorization required. Please call NDPERS Customer Service at: 1-800-499-3416 for approval. |
| | Inpatient services | 25% <u>coinsurance</u> after deductible | 20% <u>coinsurance</u> after deductible | |
| If you are pregnant | Office visits | 25% <u>coinsurance</u> | 20% <u>coinsurance</u> | Deductible is waived for prenatal and postnatal care. Deductible is waived on delivery services from a PPO healthcare provider when enrolled in the Healthy Pregnancy Program. |
| | Childbirth/delivery professional services | 25% <u>coinsurance</u> | 20% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 25% <u>coinsurance</u> | 20% <u>coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|---|
| | | Basic Plan | PPO Plan | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 25% <u>coinsurance</u> after <u>deductible</u> | 20% <u>coinsurance</u> after <u>deductible</u> | Prior authorization required. Please call NDPERS Customer Service at: 1-800-499-3416 for approval. |
| | <u>Rehabilitation services</u> Therapy: | \$30 <u>copay</u> / visit | \$25 <u>copay</u> / visit | None |
| | Other outpatient services: | 25% <u>coinsurance</u> after <u>deductible</u> | 20% <u>coinsurance</u> after <u>deductible</u> | |
| | <u>Habilitation services</u> Therapy: | \$30 <u>copay</u> / visit | \$25 <u>copay</u> / visit | None |
| | Other outpatient services: | 25% <u>coinsurance</u> after <u>deductible</u> | 20% <u>coinsurance</u> after <u>deductible</u> | |
| | <u>Skilled nursing care</u> | 25% <u>coinsurance</u> after <u>deductible</u> | 20% <u>coinsurance</u> after <u>deductible</u> | Prior authorization required. Please call NDPERS Customer Service at: 1-800-499-3416 for approval. |
| | <u>Durable medical equipment</u> | 25% <u>coinsurance</u> after <u>deductible</u> | 20% <u>coinsurance</u> after <u>deductible</u> | Prior authorization may be required. Please call NDPERS Customer Service at: 1-800-499-3416 for approval. |
| <u>Hospice services</u> | 25% <u>coinsurance</u> after <u>deductible</u> | 20% <u>coinsurance</u> after <u>deductible</u> | None | |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|-----------------------|--|----------------------------|
| • Acupuncture | • Hearing aids (unless under age 18) | • Routine eye care (Adult) |
| • Cosmetic surgery | • Long-term care | • Weight loss programs |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---------------------|--|--|
| • Bariatric Surgery | • Coverage provided outside the United States. For full details, refer to your Policy or see: sanfordhealth.com/ndpers | • Private-duty nursing |
| • Chiropractic Care | • Infertility treatment. \$20,000 lifetime maximum | • Routine foot care (for diabetics only) |
| | | • Telehealth / e-visits / video visits |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: North Dakota Department of Labor at 1-800-582-8032. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sanford Health Plan/Appeals & Complaints at 1-800-499-3416 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-892-0675 (*toll-free*).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-0675 (*toll-free*).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-892-0675 (*toll-free*).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-892-0675 (*toll-free*).

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$500
- Specialist copayment \$35
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

- The plan's overall deductible \$500
- Specialist copayment \$35
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

- The plan's overall deductible \$500
- Specialist copayment \$35
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| | |
|--|-----------------|
| Total Example Cost | \$12,700 |
| In this example, Peg would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$500 |
| Copayments | \$0 |
| Coinsurance | \$1,500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,060 |

| | |
|--|----------------|
| Total Example Cost | \$7,400 |
| In this example, Joe would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles* | \$100 |
| Copayments | \$1,300 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$1,460 |

| | |
|--|----------------|
| Total Example Cost | \$1,900 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles* | \$500 |
| Copayments | \$200 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$900 |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Sanford Wellness at 1-877-305-5463.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Non-discrimination notice

Sanford Health Plan does not discriminate against any future, current, or past Member on the basis of race; ethnicity; color; national origin; disability; sex; gender; sexual orientation; gender identity; religion; spiritual beliefs; medical condition, including a current or past history of mental health and substance use disorders; sources of payment for care; or age, in its coverage, treatment, or benefit decisions. Sanford Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, or other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Director of Customer Service, 300 Cherapa Place #201, Sioux Falls, SD 57103, (800) 752-5863, TTY/TDD (877) 652-1844, fax (605) 328-6812, memberservices@sanfordhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, (800) 537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Free help in other languages

For help in a language other than English, please call us toll-free at (800) 892-0675. Both oral and written translation services are available for free in at least 150 languages. If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-892-0675 (TTY: 1-877-652-1844).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-892-0675 (TTY: 1-877-652-1844).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-892-0675 (TTY: 1-877-652-1844).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-892-0675 (TTY: 1-877-652-1844).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-892-0675 (TTY: 1-877-652-1844).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-892-0675 (TTY: 1-877-652-1844)。

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-892-0675 (TTY: 1-877-652-1844).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-892-0675 (телетайп: 1-877-652-1844)

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-892-0675 (TTY: 1-877-652-1844).

Arabic: خدمات فإن، اللغة اذكر تتحدث كنت إذا: ملحوظة 1-877-652-1844 (رقم) والبكم الصم هاتف 1-800-892-0675 برقم اتصل. بالمجان لك تتوافر اللغوية المساعدة

Karen:

ဟံသုဉ်ဟံသး- နမုာ်ကတိာ် ကညီ ကျိဉ်အယိ, နမုာ်န့ၢ် ကျိဉ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘျုးလၢာ်စ့ၤ နီတၢ်စၢၤဘျုးသုဉ်လၢ. ကိ: 1-800-892-0675 (TTY: 1-877-652-1844).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚክተለው ቁጥር ይደውሉ 1-800-892-0675 (መስማት ለተሳናቸው: 1-877-652-1844)።

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-892-0675 (TTY: 1-877-652-1844). 번으로 전화해 주십시오.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-892-0675 (ATS : 1-877-652-1844).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-892-0675 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-877-652-1844).

Cambodian, Mon-Khmer:

សម្រាប់: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូ ទូរស័ព្ទ 1-800-892-0675 (TTY: 1-877-652-1844)។

Help understanding this document is free

If you would like this policy in another format (for example, a larger font size of a file for use with assistive technology, like a screen reader), please call us at:
(800) 752-5863 (toll-free) | TTY/TDD: (877) 652-1844